Certificate of Coverage

(herein called the "Certificate")

State of Indiana
Local Schools/Governments HEA1925

Anthem Traditional Plan II

January 2007

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

Underwritten by:

Anthem Insurance Companies, Inc.

Customer Service Number:

Business Hours are 8:00 a.m. to 6:00 p.m.

Medical Questions – 1-877-814-9709

Precertification Program Unit:
1-877-814-4803

Mental Health or Substance Abuse Program
1-800-223-7723

Employee Assistance Program
1-800-223-7723

Pharmacy Program
1-800-662-0210

Claims Mailing Address:
Anthem Insurance Companies, Inc.
PO Box 37010
Louisville, KY 40233-7010

PART I: OVERVIEW OF IMPORTANT INFORMATION

PART II: PRECERTIFICATION

PART III: BENEFITS

PART I: OVERVIEW OF IMPORTANT INFORMATION

This Plan for local public employer groups offering the State employee health Plan, as explained in this booklet, is available to you and your covered Dependents defined in Part VII of this booklet. The benefits are available for covered expenses incurred after the "Effective Date of Your Coverage" explained on Page 44.

Covered Services: Services or supplies for which benefits will be paid when rendered by Providers acting within the scope of their license. To be considered a Covered Service, charges for that service must be incurred while the Member's coverage under this Plan is in force.

All Covered Services and supplies must be Medically Necessary. Medically Necessary means that services or supplies are required for treatment of illness, injury, diseased condition or impairment and the place of treatment is appropriate for the level of care.

Covered Charges: Charges for Covered Services to the extent that in the judgment of the Plan, such charges are not excessive. The Plan will base its judgment on one or a combination of the following: a) a negotiated rate based on services provided; b) a fixed rate per day; or c) the Maximum Allowable Amount for similar Providers who perform like Covered Services.

Your Deductible: Before benefits are payable under the Medical portion of your benefits, you must first satisfy the Deductible for services with a percentage Copayment and for Prescription Drugs. The Plan Deductibles are: $500.00 per Member: $500.00 per family or With Tobacco Incentive $0.00 per Member or family. See Page 10 for further information.

Your Out-of-Pocket Expense: The Out-of-Pocket Limit includes all percentage Copayments you incur in a Benefit Period. However, Prescription Drug Copayments do not apply toward the Out-of-Pocket Limit. Transplants at a non-Network Facility do not count towards the Out-of-Pocket Expense. Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional percentage Copayments will be required for the Member and/or family for the remainder of the Benefit Period except for Prescription Drug Copayments. See page 10 for further information.

Network and non-Network Deductibles, Copayments and Out-of-Pocket Limits **do accumulate toward each other**.

Lifetime Maximum: Your Plan contains a Lifetime Maximum payment of $2,000,000.00 for all Covered Services. This means the Lifetime Maximum amount of benefit payments available to you and each of your covered Dependents, for as long as you are covered under this Plan, is $2,000,000.00. This amount includes Covered Charges for Human Organ and Tissue Transplant Services.

Blue Access Network: Your coverage includes a Provider Network. In order to receive full Plan benefits, you must choose a Provider who is a part of this Network. **If you DO NOT choose a Network Provider, you will be required to pay an additional 40% of Covered Charges, unless otherwise stated herein.** See Page 11 for further information about the Blue Access Network.

PRECERTIFICATION: When you are admitted to the Hospital for any reason other than Mental Illness or Substance Abuse, you are required to call PRECERTIFICATION and pre-certify your Hospital admission. The medical consultants in PRECERTIFICATION will coordinate your treatment program with the Hospital and your doctor, assuring you receive the best possible care, while using the most cost-effective treatments. **If you do not call PRECERTIFICATION, your lnpatient benefits will be reduced by 50%.** The phone number to call is on your Identification Card. See Page 7 for additional information about PRECERTIFICATION.

Managed Mental Health Network: When you receive **Inpatient** care for Mental Illness or Substance Abuse, you are required to call to pre-authorize your care. **If you choose a Network Provider**, you will receive full Plan benefits. **If you choose a non-Network Provider**, you will receive reduced benefits. See Page 27 for additional information about the Managed Mental Health Network.

Employee Assistance Program: The Employee Assistance Program provides consultation and referral services for human concerns for employees and their household members. See Page 28 for additional information about the Employee Assistance Program.

Pharmacy Network: When you purchase covered drugs from a **NETWORK PHARMACY**, after the Deductible is satisfied, there is a $10 Copayment for tier 1 drugs; a $20 Copayment for tier 2 drugs; or a 40% Copayment (with a minimum of $40 and a maximum of $100) for tier 3 or tier 4 drugs. When you purchase covered drugs from the **Mail Service Program**, after the Deductible is satisfied, then there is a $20 Copayment for tier 1 drugs; a $40 Copayment for tier 2 drugs; or a 40% Copayment (with a minimum of $80 and a maximum of $150) for tier 3 or tier 4 drugs. You will not need to file a claim if you receive services from a Network Pharmacy. When you purchase covered drugs from a **non-NETWORK PHARMACY**, your Copayment will be 40% of the charge for all tier drugs, subject to the Deductible. You must pay the full amount to the Pharmacy and file a claim with Anthem Insurance Companies, Inc. Your Group designee will have a supply of claim forms. **There are no non-Network benefits for the Mail Service Program.** See Page 23 for additional information about the Pharmacy Network. **Do not file the Copayment amount with Anthem Insurance Companies, Inc.**

REFER TO THE BACK PAGE OF THE FRONT COVER OR THE LAST PAGE OF THIS BOOKLET FOR PHONE NUMBERS YOU MAY CALL FOR MORE INFORMATION ON YOUR BENEFITS, THE BLUE ACCESS NETWORK, PRECERTIFICATION, THE MANAGED MENTAL HEALTH NETWORK AND THE PHARMACY NETWORK.

PART II: PRECERTIFICATION

(See Part IV, Managed Mental Health, for information on how to pre-certify Inpatient Mental Illness and Substance Abuse services.)

Health Care Management is included in the Member's health care benefits to encourage the Member to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Member's by assuring the use of appropriate procedures, setting (place of service), and resources using Precertification, Concurrent Review, and Case Management.

For each Health Care Management feature, the purpose of the feature, what is required, and effects on benefits are explained.

PRECERTIFICATION

NOTICE: Precertification does NOT guarantee coverage for or the payment of the service or procedure reviewed.

Precertification is a procedure which requires that an approval be obtained from the Plan before incurring expenses for certain Covered Services. When care is evaluated, both Medical Necessity and appropriate length of stay will be determined. For certain services the Member will be required to use the Provider designated by the Plan's Health Care Management staff. Medical Necessity includes a review of both the service and the setting. When approved, a copy of the approval will be provided to the Member, the Physician, and the Hospital or facility. The care will be covered according to the Member's benefits for the number of days approved unless the Plan's Concurrent Review determines that the number of days should be revised. Most Providers know which services require Precertification and will obtain any required Precertification. The Member's Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. If the Member uses a Non-Network Provider, the Member will be responsible for any services, which are not Medically Necessary. If a request is denied, the Provider may request a reconsideration to be completed within 3 days of the request. An expedited reconsideration may be requested when the Member's health requires an earlier decision.

The Member is requested to obtain Precertification for certain services obtained from a Non-Network Provider; or, if the Member is traveling or lives outside of the Service Area and has used the BlueCard program to obtain a Network or Participating Provider through the local Blue Cross and Blue Shield Plan.

When the Member is requested to obtain Precertification, the Member should verify that the Non-Network Provider or BlueCard Provider obtains the requested Precertification or the Member should obtain the requested Precertification. If the Member does not obtain any requested Precertification, the Member is responsible for all charges for services the Plan

determines are not Medically Necessary. If the Member fails to obtain Precertification, a retrospective review will be done to determine if the Member's care was Medically Necessary.

If the Member has any questions regarding Health Care Management or to determine which services require Precertification, the Member should call the telephone number on the back of the Identification Card.

For Emergency admissions, Precertification is not required. However, the Member or the Member's Physician is requested to notify the Plan of the admission within 48 hours or as soon as possible within a reasonable period or services after 48 hours could be denied.

CONCURRENT REVIEW

Concurrent Review is a process in which nurses monitor the Member's progress during an Inpatient admission. As a result of Concurrent Review, additional days of Inpatient care may be approved which exceed the number originally authorized by the Plan's Health Care Management staff. With prior notice from the Plan, the number of days originally authorized through Precertification may be reduced when it is determined that continued Inpatient care is no longer Medically Necessary.

For Concurrent Review, the determination should be made within one business day after all information is provided and notice of the decision is required within one business day after the determination.

CASE MANAGEMENT (INCLUDES DISCHARGE PLANNING)

Case Management is a feature designed to assure that the Member's care is provided in the most appropriate and cost effective care setting. This feature allows the Plan to customize the Member's benefits by approving otherwise non-Covered Services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by the Plan's Health Care Management staff. In managing the Member's care, the Plan has the right to authorize substitution of Outpatient Services or services in the Member's home to the extent that benefits are still available for Inpatient Services.

INTERACTIVE REAL-TIME INFORMATION SHARING (IRIS)

IRIS is a health management technique that can collect clinical health information and identify potential errors and gaps in care, helping to avert potential problems for at-risk Members before they experience dangerous, costly events. IRIS uses technology to examine current technical and historical patient information and determine risks to the patient. The at-risk Member and the Member's Physician will be contacted by one of the Plan's medical directors to discuss a coordinated plan of care. Follow-up communications may be necessary depending upon the severity of the case.

DISEASE MANAGEMENT PROGRAMS

Disease management programs offer extra information to Members who:

- are at a high risk for pregnancy complications.
- have suffered a heart attack or had surgery related to coronary artery disease.
- have diabetes.

Disease management is also provided for other chronic, complex and costly diseases including, but not limited to, asthma, chronic obstructive pulmonary disease, and congestive heart failure.

Members will receive educational information from the Plan if their claims indicate they are receiving treatment for a chronic disease. Interventions are geared for Members who present an opportunity to improve clinical, financial, safety and humanistic outcomes.

PART III: BENEFITS

PLAN DEDUCTIBLE

During each calendar year, you must first satisfy the Deductible amount shown below, before **any** benefits can be paid under the medical plan except Preventive Benefits.
The Deductible applies only to Covered Services with a percentage Copayment and for Prescription Drugs.

The Plan Deductibles are:

\$500.00 per Member,
\$500 .00 per family, Network and non-Network combined.
The Family Deductible must be satisfied by either one Member or all Members collectively before any Covered Services are paid by the Plan. **MEDICAL BENEFITS WITH A PERCENTAGE COPAYMENT AND PRESCRIPTION DRUG BENEFITS LISTED IN THIS PLAN ARE SUBJECT TO THE PLAN DEDUCTIBLE.**

OR

Tobacco Incentive: \$0.00 per Member, Network and non-Network combined.

The Deductible Period is the calendar year -- January 1 through December 31.

COPAYMENT

You will be responsible for Network Copayments stated as dollar amounts or percentages.

The Plan will reduce payment to 60% and your Copayment will increase to 40% if you receive services from a non-Network Provider, unless otherwise stated herein.

OUT-OF-POCKET LIMIT

The Out-of-Pocket Limit per calendar year of Covered Charges is:

\$2,000.00 per Member, Network and non-Network combined;
\$4,000.00 per family, Network and non-Network combined.

After you have paid the Out-of-Pocket Limit, the Plan will begin paying 100% of your Covered Charges for the remainder of that calendar year, unless otherwise stated herein.

LIFETIME MAXIMUM

The Lifetime Maximum is $2,000,000.00 per Member for all Covered Charges. This amount includes Covered Charges for Human Organ and Tissue Transplant Services.

BLUE ACCESS NETWORK

For all Covered Services there will be a non-Network penalty of 40% if a Member receives services from a Provider who is **NOT** a Network Provider. This penalty does accrue toward the maximum Out-of-Pocket Limit. Non-Network penalties will not apply to emergency accident or emergency illness care or to an employee whose principle residence is more than 30 miles from a Network Provider or to an out-of-state Provider.

HOSPITAL INPATIENT

Exception: See Managed Mental Health Care benefits for treatment of Mental Illness and Substance Abuse.

Hospital - A facility that is a short-term, acute care general Hospital and which:

- is a duly licensed facility,
- for compensation from its patients, is primarily engaged in providing Inpatient diagnosis, treatment, and care of injured and sick persons by, or under the supervision of, Physicians,
- has organized departments of medicine and major surgery, and
- provides 24-hour nursing service by, or under the supervision of, Registered Nurses.

These charges are not subject to the Deductible. Network Inpatient Facility Services are subject to a $500 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Network Inpatient Professional Services are subject to the Deductible, then payable at 100% of Covered Charges.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

OUTPATIENT SERVICES

Outpatient Services Other Than Surgery

Network Outpatient Surgical Services other than surgery are subject to the Deductible, then payable at 100% of Covered Charges.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Outpatient Surgical Services

These charges are not subject to the Deductible. Network Outpatient Facility Services are subject to a $250 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Outpatient Professional Services

Network Outpatient Professional Services are subject to the Deductible, then payable at 100% of Covered Charges.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

PHYSICIAN SERVICES

The following Physician services are covered:

- Surgery

NOTE: If more than one (1) surgical procedure is performed during one (1) session, this Plan will pay the benefits stated above for the most costly procedure. The other procedure(s) will be paid at 50% of Covered Charges. Incidental surgical procedures will not be covered by the Plan.

No additional fee will be paid to a Network Provider, for a secondary operation or procedure following the primary operation, such as reopening the incision for exploration, removal of hematoma, control of bleeding, resuturing, and similar services connected with the original service.

- Services of an assistant surgeon when your Physician needs assistance, not to exceed 20% of the total surgical allowance.

- General anesthesia when administered during surgery by a Physician other than the operating surgeon (nurse anesthetists are covered Providers).

- One consultation per Hospital Confinement for each diagnosis.

  Exception: See Managed Mental Health Care benefits for treatment of Mental Illness and Substance Abuse.

- One Inpatient medical visit per diagnosis, per Physician, each day you are hospitalized. During surgical admissions, the diagnosis must be different from the surgical diagnosis.

  Exception: See Managed Mental Health Care benefits for treatment of Mental Illness and Substance Abuse.

- Intensive medical care.

- Voluntary second or third surgical opinions.

These charges are not subject to the Deductible. Network Physician Services are subject to a $20 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Reconstructive Surgery

Covered Services for reconstructive surgery following mastectomies are:

1. reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Network benefits paid for Mastectomy Reconstruction are subject to the Deductible, then payable at 100% of Covered Charges.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Mastectomy Note

A Member who is receiving benefits for a covered Mastectomy or for follow-up care in connection with a covered Mastectomy, on or after the date of the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, will also receive coverage for:

- Reconstruction of the breast on which the Mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of Mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same Copayment provisions otherwise applicable under the Plan.

MATERNITY

These charges are not subject to the Deductible. Network Inpatient facility services are subject to a $500 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Maternity benefits are available on both single and family enrollments for services provided after the Effective Date of your coverage.

INITIAL NEWBORN TESTING

Benefits include initial newborn examinations for detecting the following disorders at the earliest feasible time: phenylketonuria; hypothyroidism, hemoglobinopathies, including sickle cell anemia; galactosemia; Maple Syrup urine disease; homocystinuria; and inborn errors of metabolism that result in mental retardation and that the State department designates; physiologic hearing screening examinations for newborns to detect hearing impairments; congenital adrenal hyperplasia; biotinidase deficiency; disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry - a newborn is exempt from this examination only if a parent objects, in writing, because of religious beliefs.

After the Deductible, your Plan will pay 100% of Covered Charges for Initial Newborn Testing.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

NEWBORN INITIAL and SUBSEQUENT EXAMS

These charges are not subject to the Deductible. Network Newborn Initial and Subsequent Exams are subject to a $20 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

HOME AND OFFICE CALLS

These charges are not subject to the Deductible. Network Home and Office Calls are subject to a $20 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

PREVENTIVE BENEFITS

Well Baby Immunizations

These charges are not subject to the Deductible. Network Well Baby Immunizations are subject to a $20 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Preventive Care

These charges are not subject to the Deductible. Network services are subject to a $20 Copayment for Routine Physicals for Members and their covered Dependents. Services include diagnostic services performed with the annual physical.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Flu Shots

These charges are not subject to the Deductible. Network Flu Shot Services are subject to a $20 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Routine Pap Smears

These charges are not subject to the Deductible. Network Routine Pap Smears are subject to a $20 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Routine Prostate Antigen Tests (PSA)

These charges are not subject to the Deductible. Network Routine Prostate Antigen Tests are subject to a $20 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Screening Colorectal Cancer Examination

Screening Colorectal Cancer Examination and related laboratory test and office visits are covered for covered Members and covered Dependents.

These charges are not subject to the Deductible. Network Colorectal Cancer Examination Services are subject to a $20 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Routine Mammograms

Benefits include one Routine Mammogram per calendar year. Additional mammography services and ultrasounds are covered as determined Medically Necessary by your Physician.

These charges are not subject to the Deductible. Network Routine Mammograms are subject to a $20 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Medical Nutritional Therapy

Medical Nutritional Therapy limited to consultations for the Medically Necessary management and treatment of obesity. Any Prescription Drug or medical supply prescribed as a part of this therapy will not be covered except as specifically stated in this booklet. This therapy is limited to services rendered by Network Providers. Charges for Medical Nutritional Therapy from a non-Network Provider are not covered under this Plan.

After the Deductible, your Plan will pay 80% of Covered Charges for Medical Nutritional Therapy.

BLOOD

After the Deductible, your Plan will pay 80% of Covered Charges for Blood.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

MEDICAL AIDS

Prosthetic Devices

Covered Services are the initial purchases, fitting, repair, and replacement of fitted devices, which replace body parts or perform bodily functions.

After the Deductible, Network Prosthetic Devices Services are payable at 80% of Covered Charges**.**

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Durable Medical Equipment

Covered Services are the rental, initial purchase, repair and replacement of equipment appropriate for home use and manufactured mainly to treat the injured or ill.

Exception: Routine maintenance is not a Covered Service and Covered Charges for deluxe items are limited to the cost of standard items.

After the Deductible, Network Durable Medical Equipment Services are payable at 80% of Covered Charges**.**

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Orthotic Appliances

Covered Services are the initial purchase, fitting, repair and replacement of braces, splints, and other appliances used to support or restrain a weak or deformed part of the body.

Exceptions: Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace, and standard elastic stockings, garter belts, and other supplies not specifically made and fitted are not Covered Services.

After the Deductible, Network Orthotic Appliances Services are payable at 80% of Covered Charges.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

OUTPATIENT DIAGNOSTIC SERVICES

The following procedures are covered when ordered by a Provider because of specific symptoms or as part of an annual physical examination:

- Radiology, ultrasound, and nuclear medicine;
- Laboratory and pathology;
- EKG, EEG, and other electronic diagnostic medical procedures;
- Psychological testing;
- Neuropsychological testing

EXCEPTIONS: Unless otherwise provided, your benefits do not include the following services:

- audiometric testing (when performed to determine the necessity of a hearing aid);
- eye refractions;
- examinations for fitting of eye glasses, contact lenses or hearing aids, dental examinations;
- premarital examinations; or
- research studies, screening examinations; physical examinations or checkups.

After the Deductible, Network Diagnostic Services performed in an Outpatient setting by a Network Provider are payable at 100% of Covered Charges.

Network Physician Office services are subject to a $20 Copayment. These charges are not subject to the Deductible.

If you receive services from a non-Network Provider, regardless of setting, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

PREADMISSION TESTING

Covered Services are necessary tests and studies performed in an Outpatient setting before an Inpatient Hospital admission.

Services are not covered if:

- Performed to establish a diagnosis.
- Repeated after admission to the Hospital.
- Performed more than seventy-two (72) hours before the date of admission.
- The admission is canceled or postponed.

Network Diagnostic Services performed in an Outpatient setting are subject to the Deductible, then payable at 100% of Covered Charges

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

DENTAL CARE

In and Outpatient Hospital and Physician charges for Dental Care are covered if you have an unrelated medical condition, which makes it unsafe to perform the dental procedure anywhere else. Benefits will be paid the same as any other condition.

Accidental Dental

Covered Services--treatment of dental caused by an accidental injury occurring after your Effective Date of coverage.

Network Accidental Dental Services are based on the place of service**.**

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

OUTPATIENT THERAPY SERVICES

Therapy services mean the following services and supplies ordered by a Provider used for the treatment of an illness or injury to promote the recovery of the Member or Covered Dependent.

- **Radiation Therapy** - Treatment of disease by x-ray, radium, or radioactive isotopes.

- **Chemotherapy** - The treatment of disease by chemical or biological antineoplastic agents.

- **Dialysis treatments** - The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body; includes hemodialysis or peritoneal dialysis.

- **Physical Therapy** - The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part. Physical Therapy is limited to 25 visits per calendar year, combined Network and non-Network charges.

- **Respiratory/Inhalation Therapy** - The introduction of dry or moist gases into the lungs for treatment purposes.

- **Occupational Therapy** - Treatment designed to improve muscle strength, joint motion, coordination and endurance of a physically disabled person, when given by a

Physical Therapist or an Occupational Therapist. Occupational Therapy is limited to 25 visits per calendar year, combined Network and non-Network charges.

- **Speech Therapy** - Treatment for the correction of a speech impairment resulting from an accident, a stroke, or surgery. Speech Therapy is limited to 25 visits per calendar year, combined Network and non-Network charges.

- **Manipulation Therapy** - Treatment includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services. Manipulation Therapy is limited to 12 visits per calendar year, combined Network and non-Network charges.

These charges are not subject to the Deductible. Network Outpatient Therapy eligible charges are subject to a $20 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

EMERGENCY CARE

Emergency Illness - A medical condition that is not accident-related and characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

- Permanently placing your health in jeopardy, or
- Other serious medical consequences, or
- Serious impairment of bodily function, or
- Serious and permanent dysfunction of any bodily organ or part.

These charges are not subject to the Deductible. Network or non-Network Outpatient Facility services paid for Emergency Illness are subject to a $75 Copayment.

These charges are not subject to the Deductible. Network or non-Network doctor's charges for Emergency Illness are subject to a $75 Copayment.

These charges are not subject to the Deductible. Network or non-Network Diagnostic charges related to Emergency Illness are subject to a $75 Copayment.

Emergency Accident - A sudden external event resulting in bodily injury. It does not include physical conditions resulting from sickness or disease.

These charges are not subject to the Deductible. Network or non-Network Emergency Accident Outpatient Facility charges are subject to a $75 Copayment.

These charges are not subject to the Deductible. Network or non-Network Emergency Accident doctor's charges are subject to a $75 Copayment.

These charges are not subject to the Deductible. Network or non-Network Diagnostic charges related to Emergency Care are subject to a $75 Copayment.

URGENT CARE SERVICES

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment. Urgent Care services can be obtained from a Network or non-Network Provider. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified for emergency room care.

These charges are not subject to the Deductible. Network or non-Network Outpatient Facility charges for Urgent Care Services are subject to a $35 Copayment.

These charges are not subject to the Deductible. Network or non-Network doctor's charges for Urgent Care Services are subject to a $35 Copayment.

TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME

Covered Services for TMJ Syndrome are Inpatient Hospital charges, office visits, Diagnostic Services, Orthotic Appliances, equilibrations, crowns, orthodontia, and surgery.

These charges are not subject to the Deductible. Network Outpatient facility services related to TMJ Syndrome are subject to a $250 Copayment.

These charges are not subject to the Deductible. Network benefits paid for Physician services related to TMJ Syndrome are subject to a $20 Copayment.

These charges are not subject to the Deductible. Network Services related to TMJ Syndrome are payable at 100% of Covered Charges.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Limit: $2,500.00 Lifetime Maximum for Covered Services related to TMJ Syndrome per covered Member.

HOME HEALTH CARE

Covered Services are non-Custodial medical and nursing care to home confined patients who are referred to a Home Health Care Agency by a Physician.

Custodial Care--is a non-Covered Service. Custodial Care is defined as:

1. Care with the primary purpose of meeting personal rather than medical needs, including services such as, assistance in walking, getting in and out of bed, dressing, feeding, use of toilet, preparation of special diets, and supervision medication, which can be self-administered.

2. Care which is not primarily provided for its therapeutic value in treatment of an illness, disease, bodily injury, or medical condition.

3. Care which persons with no special medical skills or training can provide.

The Plan will determine, based on medical evidence, whether care is Custodial. Services determined to be Custodial will not be covered, regardless of who prescribes or provides the treatment.

These charges are not subject to the Deductible. Network Home Health Care Services are subject to a $20 Copayment per day. Network Home Health Care Services include home IV therapy services.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Limits: Private Duty Nursing is limited to $5,000.00 Lifetime Maximum per covered Member.

HOSPICE CARE

Covered Services include Physician services, nursing care, medical appliances and supplies, drugs, for Outpatient care for pain relief and symptom management, Inpatient short term care including respite care, home health aids, homemaker services, physical therapy, occupational therapy, and speech pathology services, and counseling including dietary counseling.

After the Deductible, Network or non-Network Hospice Care Services are payable at 80% of Covered Charges.

AMBULANCE

Covered Services are Medically Necessary Ambulance Services, provided by a Hospital or a government certified Ambulance Service, in a vehicle designed and equipped to transport the sick and injured. Both air and ground Ambulance Services are included in this benefit.

These charges are not subject to the Deductible. Network or non-Network Ambulance Services are subject to a $50 Copayment received from a Network or non-Network Provider.

PHARMACY NETWORK

Covered Services are insulin, insulin syringes, and all drugs and medicines requiring a prescription under federal law. Covered Services also includes medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical foods means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Your Copayment amount may vary based on whether the Prescription Drug has been classified as a first, or second, or third, or fourth "tier" Drug. The determination of tiers is made by the Plan based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

- Tier 1 generally includes Generic Prescription Drugs.
- Tier 2 generally includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are preferred relative to other Drugs.
- Tier 3 generally includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are not preferred relative to other Drugs in lower tiers.
- Tier 4 generally includes injectible Drugs. The list of Tier 4 Drugs can be found at www.Anthem.com or by calling the number on the back of your ID card.

When you purchase covered drugs from a **NETWORK PHARMACY**, after the Deductible is satisfied, there is a $10 Copayment for tier 1 drugs; a $20 Copayment for tier 2 drugs; or a 40% Copayment (with a minimum of $40 and a maximum of $100) for tier 3 or tier 4 drugs. You will not need to file a claim if you receive services from a Network Pharmacy.

When you purchase covered drugs from a **non-NETWORK PHARMACY**, after the Deductible is satisfied, then your Copayment will be 40% of the charge for all tier drugs. You must pay the full amount to the Pharmacy and file a claim with Anthem Insurance Companies, Inc. Your Group designee will have a supply of claim forms. There is no non-Network Mail Service Program benefit.

NOTE: The Network penalty will be waived if there is no Network Pharmacy within 12 miles of your home.

Limits: A maximum of 34 days of medication or 100 units of medication (whichever is greater) may be purchased at one time.

EXCLUSIONS:

- Over the counter drugs
- Over the counter vitamins
- Prescription vitamins (covered if treating a medical condition)
- Retin-A (covered if treating a medical condition)
- Diet Pills (Anorexiants)
- Fluoride Supplements
- Experimental/ Investigative drugs
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.

Mail Service Program

When you purchase covered drugs from the **NETWORK Mail Service Program**,after the Deductible is satisfied, there is a $20 Copayment for tier 1 drugs; a $40 Copayment for tier 2 drugs; or a 40% Copayment (with a minimum of $80 and a maximum of $150) for tier 3 or tier 4 drugs. You will not need to file a claim if you receive services from a Network Pharmacy.

There is no non-Network Mail Service Program benefit.

EXCLUSIONS:

- Over the counter drugs
- Over the counter vitamins
- Prescription vitamins (covered if treating a medical condition)
- Retin-A (covered if treating a medical condition)
- Diet Pills (Anorexiants)
- Fluoride Supplements
- Experimental/ Investigative drugs
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.

Limits: Maximum of 90 days of medication may be purchased at one time.

CLAIMS FOR THE PHARMACY COPAYMENT ARE YOUR RESPONSIBILITY AND SHOULD NOT BE FILED WITH ANTHEM INSURANCE COMPANIES, INC.

See Part VI for "What the Medical Plan Does Not Cover."

DIABETES SELF MANAGEMENT TRAINING

Diabetes Self Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition is covered when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

These charges are subject to the Deductible. Network Diabetes Self Management Training Services are subject to a $20 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

ANESTHESIA FOR DENTAL

Covered Services -- Inpatient and/or Outpatient Provider Facility services and Inpatient and/or Outpatient Physician's services for dental care when the Provider Facility setting is necessitated by a concurrent medical condition; for a Member under age 19 years; or for a mentally or physically impaired Member.

After the Deductible, Network Anesthesia for Dental Services are payable at 80% of Covered Charges.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

LIMIT: This provision does not apply to services or supplies for Temporomandibular Joint Syndrome for mentally or physically impaired Member or for a Member under age 19 years.

MORBID OBESITY

Covered Services include surgical treatment of Morbid Obesity:

- that has persisted for at least five (5) years; and
- for which nonsurgical treatment supervised by a Physician has been unsuccessful for at least eighteen (6) consecutive months.

Under state law, the Plan cannot cover services for the surgical treatment of Morbid Obesity for a Member younger than 21 years of age unless two (2) Physicians licensed under Indiana Code 25-22.5 (one who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in Indiana) determine that the surgery is necessary to:

- save the life of the Member; or
- restore the Member's ability to maintain a major life activity (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency);

and each Physician documents in the Member's medical record the reason for the Physician's determination.

"Morbid Obesity" means:

- a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- a body mass index of at least forty (40) kilograms per meter squared without comorbidity.

For purposes of this subsection, body mass index equals weight in kilograms divided by height in meters squared.

After the Deductible, Network Morbid Obesity Services are payable at 100% of Covered Charges.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Limit: one procedure per lifetime.

PART IV: MANAGED MENTAL HEALTH

MANAGED MENTAL HEALTH (INCLUDING SUBSTANCE ABUSE)

You and your covered family members are eligible for a full range of managed Mental Health and Substance Abuse (MHSA) treatment through the Member Assistance Program (MAP).

To use the MAP services, you must call 1-800-223-7723 to get authorization. When you call, the staff will provide a referral to appropriate care and help you or your covered Dependents choose a Provider.

Inpatient Benefits and Residential Care

These charges are not subject to the Deductible. Network Inpatient Facility Services are subject to a $500 Copayment.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Network Inpatient professional services are subject to the Deductible, then payable at 100% of Covered Charges.

Network Outpatient professional services are subject to the Deductible, then payable at 100% of Covered Charges.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Remember, you need to pre-authorize all Inpatient Mental Health and Substance Abuse services.

Intensive Outpatient Benefits

Intensive Outpatient services are more highly structured and intensive (e.g. 3-4 hours a day, 3-5 times a week) than Outpatient therapy or counseling with a private Provider.

Network Outpatient professional services are subject to the Deductible, then payable at 100% of Covered Charges.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Outpatient Benefits

Network Outpatient professional services are subject to the Deductible, then payable at 100% of Covered Charges.

If you receive services from a non-Network Provider, benefits are subject to the Deductible and will decrease to 60% of Covered Charges.

Remember, to receive the highest level of benefits, you must stay within the Provider Network.
For Outpatient visits with Network Providers, you do not need to submit claims. For Outpatient visits with non-Network Providers, send claims to:

Mental Health Contractor
P.O. Box 1129
Maryland Heights MO 63043

EMPLOYEE ASSISTANCE PROGRAM

Your Employee Assistance Program (EASY) provides you and your household members with confidential consultation and referral services at no cost to you. You can receive assistance over the phone for a wide range of issues including:

- Family problems, including problems with children;
- Child care and elder care;
- Legal concerns;
- Financial issues, including budget management and debt consolidation;
- Housing concerns.

The Employee Assistance counselor will also coordinate the personal aid you receive. You may call the counselor anytime, day or night, for crisis help or any other concern. The private Employee Assistance Help Line will be answered 24 hours a day, seven days a week by an Employee Assistance counselor.

The assistance you receive is strictly confidential. Information is not shared with your employer or family members.

To reach a counselor, call toll free 1-800-223-7723.

See Part VI for "What The Medical Plan Does Not Cover."

PART V: HUMAN ORGAN TRANSPLANTS

Human Organ and Tissue Transplant Services

For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services or Physician Office Services depending where the service is performed.

Benefit Period	Total of 365 continuous days beginning 1 day immediately prior to a Covered Transplant Procedure or first myeloblation therapy (high dose chemotherapy and/or irradiation).

Non-Network Transplant Facility

Transplant Services provided through a non-Network Transplant Facility, with respect to the type of Covered Transplant Procedure performed:

If the Covered Transplant Procedure is performed in a non-Network Transplant Facility, the Plan will pay the lesser of 60% of billed charges, or 60% of the amount shown below for the actual Covered Transplant Procedure, subject to the Deductible. This amount will accrue to the $2,000,000 Lifetime Maximum. These amounts may be eligible for Covered Transplant Procedure expenses during the 30 day period beginning one day prior to the Covered Transplant Procedure for solid organ transplants, and one day prior to myeloblative therapy for bone marrow/stem cell transplants. After the 30th day, remaining transplant services other than the Covered Transplant Procedure expenses, may be eligible at 60% of billed charges for the remainder of the 365 day Benefit Period, not to exceed the $2,000,000 Lifetime Maximum.

The Maximums below include organ acquisition for a solid organ transplant; and mobilization, harvesting and storage of marrow/cells, regardless of when it occurs, for a bone marrow/stem cell transplant.

	NETWORK TRANSPLANT FACILITY	**non-NETWORK TRANSPLANT FACILITY**
Transplant Services With respect to the type of Covered Transplant Procedure performed:	These charges are subject to the Deductible. Member pays a $2,000 Copayment.	Subject to the Deductible, then the Plan pays the lesser of 60% of billed charges, or 60% of the amount shown in the schedule below.

Adult Procedures (Includes organ /tissue acquisition)	**Charge Maximum**
Adult Heart	$68,800
Adult Lung	$97,000
Adult Heart/Lung	$133,600
Adult Liver	$97,600
Adult Pancreas	$75,200
Kidney/Pancreas	$75,200
Adult Autologous Bone Marrow including High Dose Chemotherapy	$56,000
Adult **related** allogeneic Bone Marrow including High Dose Chemotherapy	$80,000
Adult **Unrelated** allogeneic Bone Marrow including High Dose Chemotherapy	$88,000

Pediatric Procedures (Includes Organ/Tissue Acquisition)	**Charge Maximum**
Pediatric Autologous Bone Marrow including High Dose Chemotherapy	$66,400
Pediatric **Related** Allogeneic Bone Marrow including High Dose Chemotherapy	$93,600
Pediatric **Unrelated** Allogeneic Bone Marrow including High Dose Chemotherapy	$115,200
Pediatric Heart	$104,000

	NETWORK TRANSPLANT FACILITY	**NON-NETWORK TRANSPLANT FACILITY**
Transportation Lodging and Meals	Included in the Transplant Services Copayment	Subject to the Deductible, then the Plan pays 60%

Reasonable and necessary travel expenses related to a transplant at a non-Network Transplant Facility are covered at the non-Network Transplant Facility Copayment level.

HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES

For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services or Physician Office Services depending where the service is performed.

Covered Transplant Procedure

Any of the following Medically Necessary Human Organ and Tissue Transplants:

Adult Procedures

- Bone marrow or stem cell including:

  - Autologous Bone Marrow including High Dose Chemotherapy

  - Related allogeneic Bone Marrow including High Dose Chemotherapy

  - Unrelated allogeneic Bone Marrow including High Dose Chemotherapy

- Heart;

- Heart/Lung;

- Lung;

- Liver;

- Pancreas and Kidney when preformed simultaneously or Pancreas transplant after a Kidney transplant (Kidney transplant alone may be covered under medical and is not part of this transplant benefit)

Pediatric Procedures

- Bone marrow or stem cell including:

  - Autologous Bone Marrow including High Dose Chemotherapy

  - Related allogeneic Bone Marrow including High Dose Chemotherapy

  - Unrelated allogeneic Bone Marrow including High Dose Chemotherapy

- Heart;

- Liver;

As additional diagnoses cease to be Experimental/Investigative, the Plan may amend the above Covered Transplant Procedure list to include such procedures.

When the Plan considers a Human Organ or Tissue Transplant to be Experimental/Investigative the transplant and all Covered Services performed in relation to the transplant are excluded under this benefit. If a covered Human Organ or Tissue Transplant is done in conjunction with an Experimental/Investigative transplant, the Plan will determine the portion of the charges which relate to the covered Human Organ or Tissue Transplant and allow only those charges.

You are strongly encouraged to call the Plan's transplant department to discuss benefit coverage when it is determined a transplant may be needed. The Plan will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, Network requirements or Benefit Booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Benefit Period

Transplant coverage starts one day prior to the organ transplant surgery or one day prior to myeloblation therapy (high dose chemotherapy and/or irradiation). Any services performed more than one day prior to the transplant are eligible for coverage under the medical benefit with the exception of services in conjunction with BMT/Stem Cell harvesting. Transplant coverage ends the earlier of the following:

- 364 days from the date of the transplant surgery or first myeloblation therapy;
- The day before a re-transplant, if within one year. (Upon re-transplant a new transplant benefit period starts.)

Transplant Related Expenses

Transplant Related Expenses mean Medically Necessary items that are required as a result of a Covered Transplant Procedure and would not be incurred if the person were not having a Covered Transplant Procedure. Services related to the diagnosis causing the need for a Covered Transplant Procedure which would have been performed whether or not the patient received a Covered Transplant Procedure are not considered a Transplant Related Expense. Transplant Related Expenses during a transplant benefit period include only the following:

- Acquisition costs, also referred to as procurement (live or cadaver). Acquisition costs include Medically Necessary services in connection with the preparation, harvesting and storage of bone marrow, stem cell or solid organ for a Covered Transplant. For a living donor, acquisition costs also include the Medically Necessary Inpatient services for the recovery of the donor post surgery and any complications that arise as a direct result of the actual acquisition procedure for a period of six weeks from the date of the acquisition or as otherwise determined within the limits determined by the Plan. Cord blood is payable if the transplant is approved. Harvesting and storage of cord blood, bone marrow or stem cells for a possible future transplant is not eligible under this transplant benefit.

- Transportation, meals and lodging. The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Plan when you obtain prior approval and are required to travel more than 75 miles from your residence to reach a Network Transplant Facility. The Plan's assistance with travel expenses includes transportation to and from the Network Provider facility, lodging and meals for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging and meals may be allowed for two companions. The Member must submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to the Plan when claims are filed. Contact the Plan for detailed information.

- Hospital charges and professional fees for the Covered Transplant Procedure.

- Inpatient Services, Outpatient Services, or Home Care Services for treatment of complications of bone marrow or stem cell transplant, or for complications and/or rejection of the transplanted organ.

- Physician fees for medical care following Hospital discharge, which are identified as post transplant.

  The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Benefit Booklet.

CASE MANAGEMENT

The Plan may assess the Member's continuing needs and discuss with the Member's physician less costly alternative means of care. Coverage will be provided for the less costly alternatives, even if such care is not specifically stated as covered.

The Copayment, schedule amounts, and maximums stated in this section will apply to the alternative care.

There is no penalty if the Member or the physician does not accept the proposed alternative care.

PART VI: WHAT THE MEDICAL PLAN DOES NOT COVER

EXCLUSIONS

The following section indicates items which are excluded and are not Covered Services. Unless otherwise stated in this Plan's Benefits' Article, no benefits are provided for care and supplies related to:

- Human organ or tissue transplants other than as specifically stated as covered in the Benefits' Article.
- Artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
- Artificial insemination.
- In vitro fertilization.
- Gamete intra fallopian transfer (GIFT).
- Immunizations except as specifically stated.
- Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- Reversal of sterilization.
- Services or supplies prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
- Hearing aids or examinations for prescribing or fitting them.
- Services, supplies, or charges which the Plan determines are not Medically Necessary or do not meet the Plan's medical policy, clinical coverage guidelines, or benefit policy guidelines.
- Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a professional. This includes services at residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
- Dental treatment, regardless of origin or cause, except as specified elsewhere in this Plan's Benefits' Article. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service as stated in this Plan's Benefits' Article) or gums, including but not limited to: extraction, restoration and replacement of teeth;
    1. Medical or surgical treatments of dental conditions; and

2. Services to improve dental clinical outcomes.

- Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
- Dental implants.
- Dental braces.
- Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
    1. transplant preparation;
    2. initiation of immunosuppresives; or
    3. direct treatment of acute traumatic injury, cancer or cleft palate.
- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
- Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Plan's Benefits' Article.
- Routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
    1. cleaning and soaking the feet;
    2. applying skin creams in order to maintain skin tone; or
    3. other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- Any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
- Examinations relating to research screenings.
- Developmental delays except for Pervasive Developmental Disorders (including Asperger's syndrome and autism) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, learning disabilities, hyperkinetic syndromes, or mental retardation (except for Prescription Drugs).
- Illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.
- Services and supplies for which you have no legal obligation to pay in the absence of this or like coverage.
- Services and supplies incurred prior to your Effective Date.
- Services and supplies incurred after the termination date of this coverage except as specified elsewhere.
- Services or supplies provided by a sanitarium, or rest cures.

- Services or supplies furnished by any person or institution acting beyond the scope of her/his/its license.
- Plan benefits to the extent that the services are a Medicare Part A or Part B liability.
- Services and supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Services and supplies to the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- Mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by the Plan or specifically stated as a Covered Service. Services or supplies if the Plan does not state that benefits are provided for them.
- Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by the Plan.
- Missed or canceled appointments.
- Completion of claim forms or charges for medical records or reports unless otherwise required by law.
- Recreation or diversional therapy.
- The cost of materials used in any Occupational Therapy.
- Personal hygiene environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.
- Hospitalization for environmental change or Provider charges connected with prescribing an environmental change.
- Weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in this Plan's Benefits' Article. Weight loss programs for medical reasons are also excluded, except certain surgical treatments of morbid obesity as required by law are covered. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
- The treatment of abuse of nicotine from tobacco or other sources, except for nicotine substitutes, which require a prescription under federal law.
- Stand-by charges of a Physician.
- Sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
- Drugs in quantities which exceed the limits established by the Plan.

- Prescription drugs, except as provided through the Pharmacy Benefits Manager.
- The prescription drug Copayment portion of the Pharmacy Benefits Manager.
- Any medications dispensed in a physician's office.
- Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
- Diagnostic testing or treatment related to infertility.
- Marital counseling.
- Services and supplies received from an individual or entity that is not a Provider, as defined in this Plan's Benefits' Article, or recognized by the Plan.
- A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- Services which are performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
- Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- Expenses incurred at a health spa or similar facility..
- Self-help training and other forms of non-medical self care, except as otherwise provided herein.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, or for licensing.
- Services and supplies for Skilled Nursing Facilities.
- EXPERIMENTAL/INVESTIGATIVE SERVICES
  Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which The Plan determines to be Experimental/Investigative is not covered under the Plan.

  The Plan will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:
    - cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
    - has been determined by the FDA to be contraindicated for the specific use; or
    - is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
    - is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
    - is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or

supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Plan. In determining whether a Service is Experimental/Investigative, the Plan will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Plan to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Plan has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

- Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- Court ordered testing or care unless Medically Necessary.
- Charges in excess of the Maximum Allowable Amount.
- Procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law. Complications directly related to cosmetic services treatment or surgery are not covered.
- Vision orthoptic training.
- Care received in an emergency room which is not Emergency Care, except as specified as covered.
- Chiropractic services rendered in the home as part of Home Care Services.
- Alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.
- Hiring, or the services of, a surrogate mother.
- Surgical treatment of gynecomastia.
- Treatment of hyperhydrosis (excessive sweating).
- Any service for which the member is responsible under the terms of this Plan to pay a Copayment or Coinsurance and the Copayment or Coinsurance is waived by a non-Network Provider.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Elective abortions.

PART VII: GENERAL INFORMATION

ELIGIBILITY

(1) All active full-time (37.5 hours per week) employees and their eligible "dependents".
(2) All appointed or elected officials and their eligible "dependents".
(3) Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.
(4) "Dependent" means:
   a) Spouse of an employee;
   b) Any unmarried dependent children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an educational institution). Such child shall remain a "dependent" until marriage or the end of the calendar year in which he/she attains age 19/23. In the event a child who is a "dependent" as defined herein, is both:
      1. incapable of self-sustaining employment by reason of mental or physical disability, and
      2. is chiefly dependent upon the employee for support and maintenance;

      prior to age 19, such child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "dependent" will continue until the employee discontinues his coverage or the disability no longer exists. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires annual documentation from a physician after the child's attainment of the limiting age.
(5) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Legislator" who meets the following:
   a) Is no longer a member of the General Assembly;
   b) Who served as a legislator for at least 10 years.

      A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator's spouse covered under the health insurance program. In addition, the surviving spouse of a legislator who has died may elect to participate in the group health insurance program if all of the following apply:
      1. The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the date of the legislator's death;
      2. The surviving spouse files a written request for insurance coverage with the employer;
      3. The surviving spouse pays an amount equal to the employer's and employee's Premium for the group health coverage for an active employee.

      The eligibility of the retired legislator's spouse, or a surviving spouse of a legislator for group health coverage is not affected by the death of the retired

legislator and is not affected by the retired legislator's eligibility for Medicare. The spouse's eligibility ends on the earliest of the following:

1. When the employer terminates the health coverage program;
2. The date of the spouse's remarriage;

"Dependent" for a "Retired Legislator" means an unmarried person who:

a. Is a dependent child, stepchild, foster child, or adopted child of a former legislator or spouse of a former legislator or a child who resides in the home of a former legislator or spouse of a former legislator who has been appointed legal guardian for the child; and

b. Is less than twenty-three (23) years of age; at least twenty-three (23) years of age, incapable of self-sustaining employment by reason of mental or physical disability, and is chiefly dependent on a former legislator or spouse of a former legislator for support and maintenance; or at least twenty-three (23) years of age and less than twenty-five (25) years of age and is enrolled in and is a full-time student at an accredited college or university.

(6) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

a) Must retire before January 1, 2007
b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
c) Must have completed twenty (20) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;
d) Must have fifteen (15) years of participation in a retirement fund.

(7) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

i. Must retire after December 31, 2006.
ii. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
iii. Must have completed fifteen (15) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement.

(8) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

i. Must have been employed as a teacher in a State institution under IC 11-10-5, IC 12-24-3, IC 16-33-3, or IC 16-33-4;
ii. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
iii. Must have fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee's retirement date; or must have completed ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee's retirement;

(9) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:

a) Retirement date is after June 30, 1990;
b) Will have reached the age of sixty-two (62) on or before retirement date;
c) Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;

d) Who has at least eight (8) years of service credit as a participant in the Judge's retirement fund, with at least eight (8) years of service credit completed immediately preceding the Judge's retirement.

(10) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meets the following:
   a) Who is a retired participant under the Prosecuting Attorney's Retirement fund;
   b) Whose retirement date is after January 1, 1990;
   c) Who is at least sixty-two (62) years of age;
   d) Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and
   e) Who has at least ten (10) years of service credit as a participant in the Prosecuting Attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.

(11) Retirees eligible under subsections 6 - 10 must file a written request for the coverage within ninety (90) days after retirement. At that time, the retiree may elect to have the retiree's spouse covered. The spouse's subsequent eligibility to continue insurance under the surviving spouse's eligibility end on the earliest of the following:
   a) Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the spouse would be eligible to remain covered until the end of the maximum period under COBRA;
   b) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.
   c) The end of the month following remarriage; or
   d) As otherwise provided in I.C. 5-10-8-8(g).

(12) Employee on a leave of absence for ninety (90) days or less and out of pay status

(13) An employee on family leave

(14) Retirees eligible under IC 5-10-12.

(15) A former legislator, dependent, or spouse as defined and pursuant to the conditions set forth in IC 5-10-8-8.2.

(16) All active and retired full-time and part-time employees, elected or appointed officers and officials of a local unit of government that elect to provide health coverage under this plan. A local unit of government is defined as follows:
   a) A city, town, county, township, public library, or school corporation
   b) Any board, commission, department, division, authority, institution, establishment, facility, or governmental unit under the supervision of either the state or a city, town, county, township, public library, or school corporation, having a payroll in relation to persons it immediately employs, even if it is not a separate taxing unit.

(17) As otherwise provided by Act of the Indiana General Assembly.

EFFECTIVE DATE OF YOUR COVERAGE

"For specific information concerning your Effective Date of coverage under this Plan, you should see your Human Resources or benefits department."

Coverage for a newborn child is effective from the moment of birth. Covered Services include the treatment of any injury or illness such as congenital deformity, hereditary complication, premature birth, and routine nursery care. Newborn must be formally added to the employee's policy through 'family status" change process. See NEWBORN INFANT COVERAGE on page 44.

NEWBORN INFANT COVERAGE

The benefits payable for covered Dependent children shall be paid for a sick or injured newborn infant of a Covered Member for the first 31 days of his or her life. The coverage for newly adopted children will be the same as for other covered Dependents. The coverage for the newborn infant or newly adopted child consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage for the newborn infant or newly adopted child shall include, but not be limited to, benefits for Inpatient or Outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

The coverage required for a newly adopted child:

1. Is effective upon the earlier of:

    a) The date of placement for the purpose of adoption; or
    b) The date of the entry of an order granting the adoptive parent custody of the child for purpose of adoption;

2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or

3. Continues unless required action as described below is not taken.

To be covered beyond the first 31 days, the newborn or newly adopted child must be added to the Covered Member's Plan enrollment within the first 31 days after birth or adoption.

If the Member must change to coverage with a higher fee to add the child, the Member will be liable for the higher fee for the entire period of the child's coverage, including the first 31 days.

QUALIFIED MEDICAL CHILD SUPPORT ORDER/COURT ORDERED HEALTH COVERAGE

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state law, to enroll your child under this Certificate, We will permit your child to enroll without regard to any enrollment limits and shall provide the benefits of this Certificate in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond the Dependent age limit. Any claims payable under this Certificate will be paid to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

FEDERAL LAWS RELATED TO YOUR COVERAGE

In the past few years, Congress has passed several laws that have affected our group health plans. These laws are designed to reduce Medicare expenditures by requiring that active employees and/or their Dependents who are either age 65 or over, or disabled to elect either:

a) our group health plan, or
b) Medicare as their primary coverage.

The preference is option (a) since option (b) would require the discontinuance of the group medical plan. In addition, Medicare no longer requires enrollment in the Part B Supplemental Medical Insurance Benefit for which there is a charge so long as you remain covered under our group medical plan.

INDIVIDUAL TERMINATION

Your coverage will terminate on the earliest of the following dates:

- On the date the group Plan is terminated.
- On the date you withdraw your enrollment and payroll deduction authorization for Premium contribution on behalf of yourself and/or your Dependents.
- On the last day of the period for which Premiums have been paid, if the Group fails to pay the required Premiums for you, except when resulting from clerical mistake or inadvertent error.
- On the last day of the period for which Premiums have been paid in which you leave or are dismissed from employment.
- On the date your Dependent(s) cease(s) to be a covered Dependent.
- Upon the date of your death, coverage for your Dependents shall terminate at the end of the period for which Premiums have been paid.
- Coverage for any covered Dependent child shall cease on the last day of the calendar year in which he/she ceases to qualify as a Dependent.

CONTINUATION COVERAGE ELIGIBILITY

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides employees and their Dependents the opportunity for continuation coverage under our group health plan after their coverage would otherwise have terminated.

- You may choose continuation coverage for yourself and your covered Dependents for up to 18 months if:
    1. Your employment is terminated, including retirement, or
    2. Your work hours are reduced, resulting in a loss of coverage.

- You or your covered Dependents may choose to extend the continuation coverage period for up to 29 months if:
    1. Social Security determines that you or your Dependent is disabled, and you notify Anthem Insurance Companies, Inc., within 60 days of the 18-month period.
    2. The disabled person would be eligible for the extended period of coverage not to exceed a total of 29 months from the date of termination, retirement, or work hour reduction, which resulted in loss of benefits.

- Your Spouse and covered Dependents may choose continuation of coverage for up to 36 months following:
    1. Your death,
    2. Divorce (you must provide notification),
    3. Your eligibility for Medicare while maintaining the continuation coverage,
    4. Ceasing to be a covered Dependent child.

CANCELLATION OF CONTINUOUS COVERAGE

Your continuous coverage may be canceled if:

- Premiums are not paid,
- You, your Spouse, or your Dependents become covered under another group health plan or Medicare, unless the group health plan contains an exclusion or limitation with respect to any pre-existing condition. Coordination of Benefits may apply.
- Your Spouse remarries and becomes covered under another group health plan.
- You cease to be disabled. You must notify Anthem Insurance Companies, Inc., within 30 days of Social Security's determination that the disability no longer exists. Coverage will terminate 30 days after the Social Security determination date.

PUBLIC EMPLOYEE CONTINUATION OF COVERAGE

If you are covered through a group that is a local unit public employer, as defined by Indiana law, you may be eligible for continuation of coverage under this Plan beyond the date your coverage would otherwise end. Please see your Group’s Human Resources or benefits department for further information concerning your eligibility for continuation of coverage.

MEDICAL EXAM

We have the right to have a Physician examine the patient when a claim is made under the Plan as often as is reasonably required during the pendency of the claim. We will notify you in advance of the time and place if such an examination is required.

FILING CLAIMS

If an Indiana Physician or Hospital treats you, most claims will be filed for you if you show the Hospital or Physician your Identification Card. The same is true if you are a Hospital bed patient at most out-of-state Hospitals. Under other conditions, however, you may be required to file your own medical claims. To do so:
Ask the Hospital employee or Physician to fill out the claim form normally filed with Anthem Insurance Companies, Inc., or obtain an itemized bill showing each service, the charge for each, and the diagnosis. The bill should also show who the patient is and describe his/her relationship to the person listed on your Identification Card.

Copy all numbers from your Identification Card on the bill or claim form and mail it to:

Anthem Insurance Companies Inc.
P.O. Box 37010
Louisville, KY 40233-7010

Try to have bills in a foreign language translated before you submit them, and mail both the bill and the translation.

KEEP A COPY OF ALL BILLS FOR YOUR RECORDS

FILING CLAIMS: MEDICARE SECONDARY

After Anthem Insurance Companies, Inc. has processed your claims, you will receive a "Notice of Your Benefits". For any eligible balance remaining for "Part B", if you are enrolled, attach that summary to a completed Medicare claim form and submit it to:

Anthem Insurance Companies, Inc.
P.O. Box 7073
Indianapolis, IN 46207

Medicare "Part A" participating Providers will file both Medicare and Anthem Insurance Companies, Inc., claims on your behalf. Medicare claims must be filed with the Medicare carrier in the state where services were performed.

NOTICE OF CLAIM

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to you. The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

CLAIM FORMS

Many Providers will file for you. If your service Provider will not file, you may send a written request for claim forms to Us. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Member
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

TIME BENEFITS PAYABLE

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information that We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until additional information requested have been received. The Plan generally will make its request for additional information within 30 days of the initial receipt of the claim and will complete the processing of the claim within 15 days after the receipt of all requested information.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

INQUIRY PROCEDURE

To assist you in answering any additional questions you may have, a toll free telephone number is available directly to the State of Indiana Operations Unit.

Medical Questions- 1-877-814-9709

COORDINATION OF BENEFITS

If you or one of your Dependents is covered by another group health Plan, and both Plans cover the same service, the total benefit paid by both Plans will be adjusted so that payment does not exceed the allowable charge for the Covered Service. You may be responsible for any amounts that are considered Deductible amounts from the primary insurance plan or any amounts that are in excess of Anthem's allowable amount.

One of the Plans will be designated "Primary", and the other will be designated "Secondary". The Primary Plan will provide its normal benefits. The Secondary Plan will pay the difference between what the Primary Plan has paid and the allowable charge. Neither Plan will provide more benefits under Coordination of Benefits than it would if there were no other coverage.

How to file under both Plans:

If the employee is the patient:

1. File under your health Plan first.
2. File under the other Plan second.

If the Spouse is the patient:

1. File under the Spouse's Plan first.
2. File under your health Plan second.

If a Dependent is the patient:

1. When two or more Plans cover the same patient and the parents are legally married:
   a) File under the Plan of the parent whose birthday falls earlier in the year first; other parent's Plan second.
   b) File under the Plan that covered the parent longer, if both parents have the same birthday; other parent's Plan second.
   c) File under the Plan without the "birthday rule" first; other Plan second.
2. When two or more Plans cover the same patient and the parents are separated or divorced, claims should be filed in this order (unless a court decree states otherwise):
   a) Under the Plan of the parent with custody, first.
   b) Under the Plan of the Spouse of the parent with custody, second.
   c) Under the Plan of the parent without custody, last.

If an active employee also has coverage as a retiree under another Plan:

1. File under the Plan, which covers the Member as an active employee first.
2. File under the Plan, which covers the Member as a retiree second.

   Both active and retiree Plans must have this rule; otherwise payment will be made by the Plan that has been in effect longer.

   When the order of payment cannot be determined in accordance with these general guidelines, file first under the Plan that has covered the patient for the longer period of time, then under the Plan that has covered the patient the shorter period of time.

   In order for us to process your claims, you should send the first Plan's Explanation of Benefits form to us when you submit your claim.

   If you or one of your Dependents is covered by two group Plans with Anthem Insurance Companies, Inc., and both cover the same service, benefits will be coordinated in a similar manner.

Limits: When this Plan is determined to be the Secondary Plan, it will not pay secondary benefits on any prescription drug charges, if such charges were incurred in connection with a prescription drug pharmacy program. An example of a prescription drug pharmacy program is the Pharmacy Network program contained in this benefit Plan.

Anthem may periodically request other insurance information from you or your covered Dependents to keep our records updated.

SUBROGATION

These provisions apply when Plan benefits are paid as a result of injuries or illness sustained by the Member and for which the Member has a right to a Recovery or has received a Recovery.

The Plan has the right to recover payments made on behalf of the Member from any party responsible for compensating the Member for the Member's injuries. The following apply:

- The Plan has the first priority for the full amount of benefits they have paid from any Recovery regardless of whether the Member is fully compensated, and regardless of whether the payments the Member receives makes the Member whole for his or her losses and injuries.

- The Member and the Member's legal representative must do whatever is necessary to enable the Plan to exercise their rights and do nothing to prejudice them.

- The Plan has the right to take whatever legal action they see fit against any party or entity to recover the benefits paid under this Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim still held by the Member, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to the Member's claim, attorney fees, other expenses or costs.

The Plan is not responsible for any attorney fees, other expenses or costs without its prior written consent. The Plan further agrees that the "common fund" doctrine does not apply to any funds recovered by any attorney hired by the Member regardless of whether funds recovered are used to repay benefits paid by the Plan.

REIMBURSEMENT

If the Member obtains a Recovery and the Plan has not been repaid for the benefits the Plan paid on the Member's behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on the Member's behalf and the following apply:

- The Member must reimburse the Plan to the extent of benefits the Plan paid on the Member's behalf from any Recovery.

- Notwithstanding any allocation made in a settlement agreement or court order, the Plan shall have a right of Recovery, in first priority, against any Recovery.

- The Member and the Member's legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of the Member's Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon the Member's receipt of the Recovery. The Member must reimburse the Plan in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The

"common fund" doctrine does not apply to any funds recovered by any attorney the Member hires regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If the Member fails to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of the Member's Recovery whichever is less, from any future benefit under the Plan if:
    1. The amount the Plan paid on the Member's behalf is not repaid or otherwise recovered by the Plan; or
    2. The Member fails to cooperate.

- In the event that the Member fails to disclose to the Plan and/or the State the amount of the Member's settlement, the Plan shall be entitled to deduct the amount of the lien from any future benefit under the Plan.

- The Plan shall also be entitled to recover any of the unsatisfied portions of the amount they have paid or the amount of the Member's settlement, whichever is less, directly from the Providers to whom the Plan has made payments. In such a circumstance, it may then be the Member's obligation to pay the Provider the full billed amount, and the Plan would not have any obligation to pay the Provider.

- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make the Member whole.

THE MEMBER'S DUTIES

The Member must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to the Member occurred and all information regarding the parties involved.

The Member must cooperate with the Plan in the investigation, settlement and protection of the rights of the Plan.

The Member must not do anything to prejudice the rights of the Plan.

The Member must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to the Member.

The Member must promptly notify the Plan if the Member retains an attorney or if a lawsuit is filed on the Member's behalf.

WORKER'S COMPENSATION

The benefits that would be payable under your Plan will be reduced by charges payable under the Worker's Compensation and Occupational Disease Law.

RIGHT OF RECOVERY

We may recover any incorrect payment. If the incorrect payment is made directly to you, we may deduct it from future payments made directly to you.

BLUECARD PROGRAM

When the Member receives health care services outside the geographic area served by Anthem Blue Cross and Blue Shield and those services are administered through the BlueCard Program, the amount the Member pays for Covered Charges will usually be calculated on the **lower** of:

- The Provider's actual billed charges for the Member's Covered Services, or
- The negotiated price passed on to Anthem by the Blue Cross and/or Blue Shield Plan within the area where services are received.

Often, this "negotiated price" will consist of a simple discount. But sometimes it is an estimated final price that includes expected settlements and other non-claims transactions with a Provider or with a discount from billed charges that reflects **average** expected savings. The estimated or average price may be prospectively adjusted to correct for over- or underestimation of past prices.

In addition, laws in certain states require Blue Cross and/or Blue Shield Plans to use a basis for calculating the Member's payment for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim. When the Member receives Covered Services for health care in those states, the Member's payment will be calculated using their statutory methods.

LEGAL ACTION

No legal action to obtain the Plan's benefits may be taken prior to 60 days after the Plan received the claim, or later than three (3) years after the date the claim is required to be furnished to the Plan.

NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS

Neither the Plan nor the Group is responsible for the quality of care you or your Dependents receive from any person. This Plan does not give anyone any claim, right, or cause of action against the Plan or the Group, based on what a Provider of health care or supplies does or does not do.

DEFINITIONS

This section defines terms that have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

"Ambulatory Surgical Facility" means a facility that is so licensed by the state in which it operates. If that state does not issue such licenses, it means a facility with an organized staffs of Physicians which:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis, and
- provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility, and
- does not provide Inpatient accommodation, and
- is not, other than incidentally, a facility used as an office or clinic for the private practice of a Provider,
- has appropriate government planning approval, if required by its state law; and

"Appeal" means a formal request by the Member or the Member's representative for reconsideration of a decision not resolved to the Member's satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of the Member's Grievance.

"Benefit Maximum" means the total dollar amount of benefits for which the Plan is liable under this Plan's Benefits Article.

"Brand Name Drug" means the initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own Brand Name, or under the drug's chemical name (Generic).

"Certificate" means this summary of the terms of your benefits. It is attached to and is a part of the Contract and it is subject to the terms of the Contract.

"Certified Registered Nurse Anesthetist" means any individual licensed as a Registered Nurse by the state in which he or she practices, holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

"Clinical Laboratory" means a laboratory that performs clinical procedures and is not affiliated or associated with a Hospital, Physician, or other Provider.

"Community Mental Health Center" means a facility which, (1) offers a program of services approved by the Indiana Department of Mental Health, or by the state in which it operates, (2) is organized for the purpose of providing multiple services for persons with Mental Illness, including Substance Abuse, and (3) is operated by one or more of the entities incorporated under I.C. 23-17 or similar entities of the state where it is located.

"Confinement" means a period beginning on the day a Member enters a Provider facility as a patient and ending on the day the Member leaves that facility or, if the Member was transferred from one Provider facility to another, the day on which the Member leaves the last facility. In order for a new Confinement to begin, a specified number of renewal days must elapse before the Member is readmitted to a Provider facility.

"Contract" means all of the following: 1) this Certificate, all Contract Schedules, Attachments, Addendum's and Riders; 2) all applications to establish and change enrollments that have been accepted by the Plan; 3) all Identification Cards; and 4) the Contract between the State of Indiana and Anthem Insurance Companies, Inc.

"Contract Year" means: January 1 through December 31.

"Copayment" means the percentage of Covered Charges or the flat dollar amounts for which the Member is responsible under the terms of the Plan. Copayment takes effect after any Out-of-Pocket Limit is reached.

"Covered Charges" means charges for Covered Services to the extent that, in the judgment of the Plan such charges are not excessive. The Plan will base its judgment on one or a combination of the following: a) a negotiated rate based on services provided; b) a fixed rate per day; c) the Maximum Allowable Amount for similar Providers who perform like Covered Services.

"Covered Member" means a person who meets the guidelines for eligibility under the Plan.

"Covered Services" means services or supplies specified in this Certificate for which benefits will be paid when provided by a Provider acting within the scope of his/her/its license. In order to be considered a Covered Service, charges for that service must be incurred while the Member's coverage under this Certificate is in force.

"Covered Transplant Procedure" - Any of the Medically Necessary non-Experimental/Investigative human organ and tissue transplants as described in this Certificate.

"Custodial Care" means care whose primary purpose is to meet personal rather than medical needs, which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or medical condition, and which can be provided by persons with no special medical skills or training. Such care includes, but is not limited to, helping a patient walk, get in or out of bed, and take normally self-administered medicine. The Plan will determine, based on reasonable medical evidence, whether care is Custodial.

"Day Psychiatric Facility" means a facility licensed or certified by the state in which it operates as a Provider of rehabilitation and therapeutic services for the treatment of Mental Illness, including Substance Abuse only during the day.

"Dentist" means a duly licensed Dentist or Physician who is performing services within the scope of his or her license.

"Dependent" means Spouse of an employee, any unmarried Dependent children, step-children, foster children, legally adopted children or children who reside in the Member's home for whom the Member or Spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an accredited educational institution). Such child shall remain a "Dependent" until marriage or the end of the calendar year in which he/she attains age 19/23. In the event a child who is a "Dependent" as defined herein, is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the employee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "Dependent" will continue until the employee discontinues his coverage or the disability no longer exists.

"Dependent Limiting Age" The Limiting Age is the end of the Calendar Year of the child's 19th birthday, or if the child is a full-time student, the end of the calendar year of the child's 23rd birthday.

"Diagnostic Services" means the following procedures ordered by a Provider, because of specific symptoms, in order to determine a definite condition or disease:

- Radiology, ultrasound, and nuclear medicine;
- Laboratory and pathology;
- EKG, EEG, and other electronic diagnostic medical procedures;
- Psychological testing;
- Neuropsychological testing.

Diagnostic Services are covered to the extent specified under this Plan's Benefits Article.

"Effective Date" means the date that an employee's coverage begins under the Plan. You must be actively at work on your Effective Date for your coverage to begin. Coverage for Dependents takes effect when the employee becomes covered.

Newborns are covered from and after the moment of birth for injuries or sickness, congenital deformities, including expenses arising from medical treatment for birth defects known as cleft lip and cleft palate, hereditary complications, premature birth and routine nursery care. Continued coverage requires adding Dependents to existing coverage by the 30th day from birth.

If these complications occur on a single membership, the baby is covered for thirty-one (31) days from the date of birth. Continued coverage requires election of family coverage by the 30th day from birth.

"Expedited Review" means the expedited handling of a Grievance or Appeal concerning Our denial of precertification or coverage for services. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-Expedited Review could seriously jeopardize your life, health or your ability to regain maximum function.

"Experimental/Investigative" means any drug, device, diagnostic, product, equipment, procedure, treatment, or supply (service) for which the Plan determines that one or more of the criteria listed below apply to the service when it is rendered for the evaluation or treatment of a disease, injury, illness or condition. The criteria must apply to the service at the time the Member, receives or will receive the service, and must apply to the medical use for which benefits are sought. The service:

- cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- is the subject of a current drug or device application on file with the FDA;
- is provided as part of a Phase I or Phase II clinical trial, is provided as the experimental or research arm of a Phase III clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service;
- is provided pursuant to a written protocol or other document that lists an evaluation of the service's safely, toxicity, or efficacy among its objectives;
- is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
- is provided pursuant to informed consent documents that describe the service as Experimental/Investigative, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative if the Plan determines that the service meets any of the four criteria below:

- the scientific evidence does not permit conclusions concerning the effect of the service on health outcomes;
- the service does not improve net health outcome by producing beneficial effects that outweigh any harmful effects;
- the service has not been shown to be as beneficial as any of the established alternative services with evidence demonstrating that the service improves net health outcome as much as, or more than, established alternatives; or
- the service has not been shown to improve net health outcomes under the usual conditions of medical practice outside clinical investigatory settings.

Documents relied upon by the Plan to determine whether services are Experimental/Investigative based on the criteria in the above subsections may, at the Plan's discretion, include one or more items from the following list which is not all inclusive:

- the Member's medical records;
- the written protocol(s) or other document(s) pursuant to which the service has been or will be provided;

- the published, authoritative, peer-review medical or scientific literature regarding the service as it applies to the Member's condition;
- any consent document(s) the Member or Member's representative have executed or will be asked to execute to receive the service;
- the relevant documents of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided;
- any records, regulations, applications or other documents or actions issued by, filed with, or received by the FDA, the Office of Technology Assessment, or other federal or state agencies with similar functions, that the Plan has in its possession at the time of the review; or
- opinions and evaluations by national medical associations or committees, consensus panels, or other technology evaluation bodies, such as the Blue Cross and Blue Shield Association's Technology Evaluation Center.

Services provided solely or primarily to support the administration of an Experimental/Investigative service, or those provided to treat anticipated or unanticipated results of an Experimental/Investigative service, will also be excluded from coverage. Services that are part of the same plan of evaluation or treatment as an Experimental/Investigative service, but which, in the opinion of the Plan, would, in the absence of the Experimental/Investigative service be otherwise Medically Necessary, may be considered eligible for coverage, subject to all benefit requirements, limitations and exclusions.

The Plan has the sole authority and discretion to determine all questions pertaining to whether a service is Experimental/Investigative under this Plan.

"External Grievance" means the Member's right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to the Member. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Certificate.

"Freestanding Dialysis Facility" means a facility which is primarily engaged in providing dialysis treatment, maintenance, or training to patient on an Outpatient or home care basis.

"Generic Drugs" means drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under the registered trade name or trademark. A drug who active ingredients duplicate those of a Brand Name Drug and is its bioequivalent. Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug. On average, Generic Drugs cost about half as much as the counterpart Brand Name Drug.

"Grievance" means any expression of dissatisfaction made by the Member or the Member's representative to the Plan or its affiliates in which the Member has the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concern about:

- a determination that a proposed service is not appropriate or Medically Necessary;
- a determination that a proposed service is Experimental/Investigative;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between the Member and the Plan or the Group and the Plan.

"Group" means the employer or other entity that has entered into a Contract with the Plan.

"Home Antibiotic IV Therapy" means the administration of antibiotics intravenously, by trained personnel, in the patient's home.

"Home Health Care Agency" means an agency meeting Medicare requirements and licensed by the state(s) in which it operates to provide Home Health Care.

"Hospice" means a coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

"Hospital" means a facility, which is a short-term, acute care general Hospital and which:

a. is a duly licensed facility, and
b. for compensation from its patients, is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons by or under the supervision of Physicians, and
c. has organized departments of medicine and major surgery, and
d. provides 24-hour nursing service by or under the supervision of RNs.

"Identification Card" means a card issued by the Plan that bears the Member's name, identifies his or her benefit program by number, and may contain further information about his or her coverage.

"Inpatient" means a Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

"Intermediate Care Facility" means a licensed, residential public or private Substance Abuse Rehabilitation Facility that is not a Hospital and is operated primarily to provide continuous, structured 24 hour a day or partial, less than 24 hours a day, treatment and care consisting of chemotherapy, counseling, detoxification, and/or ancillary services, identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs.

"Licensed Practical Nurse" (LPN) means a person who has graduated from a formal practical nursing education program and is licensed as such by appropriate state authority.

"Lifetime Maximum" means the total dollar amount of benefits for which the Plan is liable under this Plan's Benefits Article.

"Mail Service" means a prescription drug program which offers a convenient means of obtaining maintenance medications by mail if the Member takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to the Member's home.

"Maximum Allowable Amount" - The amount that We determine is the maximum amount payable for Covered Services you receive, up to but not to exceed charges actually billed. Our determination considers:

- amounts charged by other Providers for the same or similar service;
- any unusual medical circumstances requiring additional time, skill or experience; and/or
- other factors We determine are relevant, including but not limited to, a resource based relative value scale.
- The amount accepted by a Network Provider as payment in full under the participation agreement for this product.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For a non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with Us for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this Product.

For a non-Network Provider which is a facility, the Maximum Allowable Amount is equal to an amount negotiated with that Non-Network Provider facility for Covered Services under this product or any other product. In the absence of a negotiated amount, We shall have discretionary authority to establish as We deem appropriate, the Maximum Allowable Amount for a on-Network Provider facility. The Maximum Allowable Amount is the lesser of the Non-network Provider facility's charge, or an amount determined by Us after consideration of industry cost, reimbursement, utilization data and other factors We deem appropriate. It is your

obligation to pay any Copayments and any amounts which exceed the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with Us.

"Medically Necessary or Medical Necessity" means services or supplies received for the treatment of an illness or injury or other health condition that is determined to be:

- appropriate and consistent with the diagnosis or symptoms, and consistent with accepted medical standards;
- not chiefly Custodial in nature;
- not Experimental/Investigative or unproven;
- not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment, and as to institutional care, cannot be provided in any other setting, such as a Physician's office or the outpatient department of a Hospital, without adversely affecting the patient's condition; and
- not provided only as a convenience to you, your Physician or another Provider or person.

The fact that any particular Provider may prescribe, order, recommend, or approve a service, supply of level of care does not, of itself, make such treatment Medically Necessary or make the charge a Covered Charge under this Plan.

"Medicare" means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

"Member" means anyone provided coverage by the express terms of this Plan, whether enrolled as a Covered Person or a Dependent.

"Mental Health Conditions (including Substance Abuse)" means a condition identified as a mental disorder in the most current version of the International Classification of Diseases, in the chapter titled "Mental Disorders".

- Mental Health is a condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical causes.
- Substance Abuse is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the most current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classifications of Diseases (ICD) Manual.

"Mental Health/Substance Abuse Subcontractor" - An organization or entity that the Plan has a contract with to provide administrative and claims payment services and/or Covered Services regarding Mental Health/Substance Abuse services under this Certificate. These administrative services may also be provided directly by the Plan.

"Mental Health Treatment Center" means a treatment facility organized to provide care and treatment for Mental Illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a Physician. The facility shall be:

- Licensed by the state in which it operates;
- Funded or eligible for funding under federal or state law; or
- Affiliated with a Hospital under a contractual agreement with an established system for patient referral.

"Network Provider" means the Provider who has entered into a contractual agreement or is otherwise engaged by the Plan, or with another organization which has an agreement with the Plan, to provide Covered Services and certain administrative functions to the Member for the network associated with this Certificate.

"Night Psychiatric Facility" means a place where patients with Mental Illness, including Substance Abuse, who are capable or remaining in the community during the day, can receive treatment at night. A Night Psychiatric Facility may be a ward or wing of a Hospital or Psychiatric Hospital or it may be an independent facility that has been licensed or certified by the state in which it operates as a Provider of psychiatric night care and assumes responsibility for coordinating care of all patients.

"Non-Network Provider" means a Provider who has not entered into a contractual agreement with the Plan or is not otherwise engaged by Us.

"Occupational Therapist" means a person who is licensed as such by the state in which he or she practices or, if that states does not issue such licenses, it means a person certified as such by an appropriate professional body.

"Out-of-Pocket Limit" means the amount of Covered Charges which a Member must pay before his or her benefits under this Plan increase to 100% of Covered Charges for the remainder of the period. Covered Charges for Prescription Drug Copayments do not accrue to the Out-of-Pocket Limit and benefits for them do not increase to 100% of Covered Charges when the Out-of-Pocket Limit is reached.

"Outpatient" means a Member who is a patient, other than a bed patient, at a Provider Facility.

"Outpatient Psychiatric Facility" means a facility licensed or certified by the state in which it operates as a Provider of rehabilitation and therapeutic services for the treatment of Mental Illness, including Substance Abuse, on an Outpatient basis.

"Partial Hospitalization" means a psychiatric service offered in a Hospital or in a psychiatric day care treatment center or in a Community Mental Health Center providing medically directed intensive or intermediate short-term psychiatric treatment for a period of less than 24 hours but more than 4 hours a day for any individual patient.

"Pharmacy" means any facility so licensed by the state in which it operates to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a non-Network Provider.

"Physical Therapist" means a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.

"Physician" means a doctor of medicine, a doctor of osteopathy, a Psychologist, a chiropractor or any other practitioner of the healing arts who is licensed by the appropriate agency, is practicing within the scope of that license and:

- Is not a Member receiving treatment for himself or herself; and
- Is not a person who usually resides in the same household with the patient; or is related by blood, marriage, or legal adoption to the patient or the employee's Spouse.

"Plan" (We, Us, Our) - Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Certificate.

"Plan Deductible" means a specified amount of Covered Services, usually expressed in dollars, that must be incurred by a Member before the Plan will assume any liability for all or part of the remaining Covered Services. The Deductible will not apply to expenses for routine nursery care and supplies incurred by a newborn, if the mother has maternity coverage. If two or more persons covered by the same coverage are injured in the same accident, only a single Deductible will be applied to all Covered Charges that are accident related.

"Plan Enrollment" means a Covered Member's or Dependent's right to this Plan's benefits subject to its Exclusions, limitations, and conditions.

"Plan Year" means the 12-month period beginning each January 1.

"Premium" means the periodic charges which the Member or the Group must pay the Plan to maintain coverage.

"Psychiatric Hospital" means a facility licensed by the state in which it operates to provide diagnostic and therapeutic services for treatment of Mental Illness, including Substance Abuse, on an Inpatient basis. If the state does not issue such licenses, it means a facility which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness and Substance Abuse, if such services are provided by or under the supervision of an organized staff of Physicians and if continuous nursing services are provided by RNs.

"Psychologist" means a person certified by the Indiana State Board of Examiners in Psychology or, outside the State of Indiana, one who is licensed or certified as such by the state in which he or she practices. Where there is no state licensure or certification, the Psychologist must be certified by an appropriate professional body

"Recovery" means money you receive from another, their insurer or from any Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

"Registered Nurse" (RN) means a person who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed as such by appropriate state authority.

"Rehabilitation Facility" means a facility licensed by the state in which it operates to provide rehabilitative care on an Inpatient or Outpatient basis. If the state does not issue such licenses, it means a facility which is primarily engaged in providing medical, social, educational, and vocational services to enable patients, when the services are Medically Necessary, to achieve the highest possible level of functional ability. Services must be provided by or under the supervision of an organized staff of Physicians and continuous nursing services must be provided under the supervision of Registered Nurses.

"Residential Short Term Detoxification Facility" means a facility licensed or certified by the state in which it operates to provide 24-hour supervision in a structured therapeutic environment for the treatment and re socialization of Substance Abuse patients.

"Respiratory Inhalation Therapist" means a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.

"Semi-private room" means the charge made by a Hospital for a room containing two or more beds.

"Service Area" means the geographical area within which Network Provider services are available.

"Speech Pathologist or Speech Therapist" means a person so licensed by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as a Speech Pathologist or Speech Therapist by an appropriate professional body.

"Skilled Care" means (1) the recognition and utilization of professional methods and procedures in the assessment, observation, or treatment of an illness or injury; and (2) must be performed by or under the supervision of licensed health care personnel.

"Spouse" means the person recognized as the Covered Member's husband or wife under the laws of the state where the Contract is held.

"Substance Abuse Facility" means a facility licensed or certified by the state in which it operates as a provider of detoxification and/or rehabilitation treatment for Substance Abuse patients.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on Our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative due to federal and state patient confidentiality laws.

We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a signed Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time or after hours leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 6227,Indianapolis, IN 46206-6227, ATTN: Appeals Specialist.

Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 5 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance does not relate to an adverse certification decision (i.e., Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by Us, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Covered Member. Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request.

Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the appeal for consideration by the appeal panel whether or not You choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting, unless your Appeal qualifies for Expedited Review. Appeals concerning adverse certification decisions or the denial of any other prior authorization required by the Plan will be resolved by the panel no later than 30 calendar

days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your Physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending Physician or ordering Provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending Physician or ordering Provider, and to the facility rendering the service.

External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

- Your Appeal is regarding:
  1. an adverse determination of appropriateness; or
  2. an adverse determination of Medical Necessity; or
  3. a determination that a proposed service is Experimental/Investigational made by Us or an agent of Ours regarding a service proposed by the treating Physician; and
- You or your representative request the External Grievance in writing within forty-five (45) days after You are notified of the Appeal panel's decision concerning your Appeal; and
- The service is not specifically excluded in this Certificate.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if

an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is received by Us after the end of the calendar year plus 12 months have passed since the incident leading to your Grievance. We will accept Appeals filed within 60 days after you are notified of Our decision concerning your Grievance. We will accept External Grievance requests filed within 45 days after you are notified of our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

FOR QUESTIONS ABOUT BENEFITS, CLAIMS, ENROLLMENTS, OR BILLINGS

CUSTOMER SERVICE NUMBER

Business Hours are 8:00 A.M. to 6:00 P.M.

Medical Questions –1-877-814-9709

PRECERTIFICATION

1-877-814-4803

MENTAL HEALTH OR SUBSTANCE ABUSE PROGRAM

1-800-223-7723

EMPLOYEE ASSISTANCE PROGRAM

1-800-223-7723

PHARMACY NETWORK

1-800-662-0210

PLEASE HAVE YOUR IDENTIFICATION NUMBER READY WHEN YOU CALL